

**THE UNIVERSITY OF TEXAS AT AUSTIN
CONSENT TO TREAT A MINOR**

FOR PROVIDER USE ONLY

Patient Name: _____
 Medical Record #: _____
 DOB: _____ Gender: _____
 Provider: _____ Date: _____

Name of Program Participant:

Jane Smith

Date of Birth: **01/01/2001**

Address (Street, City, State, Zip): **1 Sample Way, Sample, TX 12345**

Parent/Guardian Phone Number: **(123) 456-7890**
Home

(321) 654-0987
Work/Cell

I, the undersigned, as the parent or legal guardian of **Jane Smith** (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending provider, appropriate staff, and The University of Texas at Austin and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

John Smith
Signature of Parent/Legal Guardian

01/19/2011

Date

John Smith

Print Name

I have received a copy of UT's *Notice of Privacy Practices* as required by HIPAA Privacy Rules.

John Smith
Signature of Parent/Legal Guardian

01/19/2011

Date

John Smith

Print Name

Medical Information Related to Minor

Allergies: **None Known**

Current Medications: (If your child is on any medication that needs to be administered by camp personnel or he/she will be self-administering any medication during camp – prescription or over-the-counter – see the appropriate medication forms enclosed in this packet for completion).

Date of Last Tetanus Booster: **01/01/2012**

Pertinent Medical History: **N / A**

Please Return to Program Coordinator:

Name of Program: **Texas Volleyball Camp**

Program Coordinator: **Nathan Mendoza**

Coordinator's Phone: **(512) 471-0804** Coordinator's Fax: **(512) 471-9069**

Coordinator's Mailing Address: **The University of Texas at Austin | Texas Volleyball Camp | P.O. Box 7399 |**
(Street) (City) (State) (Zip Code)

Minor

THE UNIVERSITY OF TEXAS AT AUSTIN
University Sponsored Summer Sports Camps
Department of Intercollegiate Athletics

PRE-ACTIVITY CLEARANCE EXAMINATION:
PHYSICIAN AUTHORIZATION

Participant's Name Jane Smith

Camp Texas Volleyball Camp

I hereby certify that I have examined the above named patient and have found him/her fit to attend and participate in the *University Sponsored Summer Sport Camps*. I know of no impairments, which would limit his/her participation in all camp activities except those that I have listed below. I further certify that he/she is free from any and all contagious diseases.

Restrictions and/or Comments _____

N/A

Date of Physical Examination (must have been completed within the last 12 months)
01/01/2012

Physician's Signature Dr. Joel Tester

Address 4321 Test Road

City/St./Zip Sample, TX 12345

Phone (147) 852-0369

THE UNIVERSITY OF TEXAS AT AUSTIN
University Sponsored Summer Sports Camps
Department of Intercollegiate Athletics

PERMISSION TO DISPENSE MEDICATIONS

CAMPER'S NAME Jane Smith DATE: 01/19/2011

The UT Sponsored Sports Camp's designated personnel will not dispense non-prescription (Advil, etc.) or prescription medication (antibiotics, insulin, inhalers, etc.) to the above named participant until the following information has been completed by a parent or guardian. I understand it is the parent's/guardian's responsibility to give the medication directly to the camp director or designated staff member in individual dosage containers, original prescriptions containers, or envelopes clearly labeled with dosage instructions on the first day of camp. In all cases, the recommended dosage of any over-the-counter medication will be adhered to according to the manufacturer's instructions and the recommended dosage of any prescription medication will be adhered to according to the following instructions:

I John Smith, the parent/guardian of Jane Smith give permission to the staff of the UT Sponsored Sports Camp to administer to my child:

PRESCRIPTION MEDICATION N/A

Dosage Dispensing Time

Special Storage Instructions

PRESCRIPTION MEDICATION

Dosage Dispensing Time

Special Storage Instructions

NON-PRESCRIPTION MEDICATIONS:

Ibuprofen (Advil) YES NO; Acetaminophen (Tylenol) YES NO;

Antacids / Anti-Nausea: Maalox YES NO; Throat / Cough Lozenges: Cepacol YES NO;

Allergies: Benadryl YES NO

Other Non-prescription Medicine which may be administered: None

My child may possess and self administer the following medicine: None, and I affirm that my child understands and agrees that he/she will use the medication only according to dosage instructions, and will not share or otherwise provide medication to any other person while at camp, and failure to do so is a violation of camp rules that will result in disciplinary action, up to and including removal from camp.

I hereby release The University of Texas at Austin, its Board of Regents, officers, employees, and representatives from any and all liability in any way resulting or arising from the administering of the above medications.

John Smith Signature of Parent or Guardian 01/19/2011 Date

THE UNIVERSITY OF TEXAS AT AUSTIN
University Sponsored Summer Sports Camps

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO CAMP STAFF

This authorizes The University of Texas at Austin physicians, medical personnel and camp sponsors to release information concerning the medical status, medical condition, injuries, prognosis, diagnosis and related personally identifiable health information of Jane Smith (Participant) to camp staff. This information includes injuries or illnesses relevant to participation in the above named camp at The University of Texas at Austin.

The reason for this disclosure is to advise camp staff of the nature, diagnosis, prognosis or treatment concerning any medical condition and any injuries or illnesses Participant may have so that good decisions can be made regarding Participant's ability and suitability to participate in camp activities. I understand that the entities that receive the information are not health care providers or health plans covered by federal privacy regulations, and that the information described above may be redisclosed publicly and that the information will no longer be protected by those regulations.

I understand that The University of Texas at Austin will not receive compensation for its use/disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by notifying in writing the Department of Intercollegiate Athletics, but if I do, it will not have any effect on actions The University took in reliance on this authorization prior to receiving the revocation. This authorization expires one year from the date it is signed.

Jane Smith 01/19/2011
Signature of Camper Date

John Smith 01/19/2011
Signature of Parent/Legal Guardian Date
(If camper is under 18 years of age)

Camper's Date of Birth: 01/01/2001

Camp Texas Volleyball Camp